New Jersey State Health Benefits Program

Internet Edition

Health Capsule

The Division of Pensions and Benefits ◆ For State Employees ◆ Issue #9

April 2000

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April is SHBP Open Enrollment month

The State Health Benefits Program (SHBP) Open Enrollment period begins, for all eligible State employees, on April 1, 2000 and ends on April 30, 2000. Coverage changes made during the Open Enrollment period will be effective on July 1, 2000 for all State employees.

The annual Open Enrollment period is your opportunity to review your health benefits coverage and, if desired, make any changes to the coverage provided to you and your dependents. During the Open Enrollment period, you may:

- enroll in any of the plans offered by the SHBP, if you have not previously done so;
- change to another SHBP health or dental plan;
- add eligible dependents you have not previously enrolled; and
- drop dependents (this can also be done at any time during the year).

Be sure to read this issue of the *Health Capsule* to see if there are any changes to your benefits that may affect your Open Enrollment decisions. Should you wish to change your coverage, you must obtain an application from your Human Resources representative. You can make changes to health or prescription drug coverage on the same application, but there is a separate application for changes to dental coverage. Completed applications must be returned to your Human Resources representative by April 30, 2000.

*(Continued on page 3, see **Open Enrollment**)*

SHBP to change plan year

Plan rates to be based on the calendar year beginning January 1, 2001

With the start of the Spring Open Enrollment, the Division of Pensions and Benefits begins the process of changing the State Health Benefits Program's (SHBP) plan year from a *fiscal* year (July 1 – June 30) to a *calendar* year (January 1 – December 31). To accomplish this change, the SHBP will conduct two Open Enrollments in 2000.

The first is the current Spring Open Enrollment with changes to be effective July 1, 2000. The second Open Enrollment will take place in the fall of 2000 with changes to be effective January 1, 2001. Thereafter, the Open Enrollment periods will occur each fall, with coverage effective January 1 of the following year. This means that **there will be no Open Enrollment in the spring of 2001.**

*(Continued on page 2, see **Plan year**)*

Changes to SHBP health plans for 2000

Since the last Open Enrollment, some State Health Benefits Program (SHBP) health plans have made changes to the benefits they offer. Outlined below are changes that have taken place for the start of the new plan year on July 1, 2000.

PRUDENTIAL HEALTHCARE HMO/AETNA US HEALTHCARE — Aetna US Healthcare has acquired Prudential HealthCare HMO for the plan year beginning July 2000. This action comes as a result of the August 6, 1999 approval by the Department of Health and Senior Services and the Department of Banking and Insurance, of the purchase of Prudential HealthCare, Inc. by Aetna, Inc. SHBP members enrolled in Prudential will be automatically transferred to Aetna US Healthcare, effective July 1, 2000, unless the employee changes to another SHBP health plan during this Open Enrollment period. Prudential members should continue to use their Prudential identification cards and may continue to see their Prudential Primary Care Physician (PCP) through June 30, 2000. Prudential members should receive their new ID cards from Aetna US Healthcare by July 1, 2000.

Prudential members should also check with their Prudential PCP to determine if the physician plans to participate with Aetna US Healthcare after July 1, 2000. If your Prudential PCP will not be joining with Aetna US Healthcare, you need to choose an Aetna US Healthcare PCP before July 1, 2000, or change to a different SHBP plan.

Prudential members who wish to change to a health plan other than Aetna US Healthcare should do so by submitting an application for change to their benefits administrator before April 30, 2000.

PHYSICIANS HEALTH SERVICES — The State Health Benefits Commission has approved a pilot program, effective July 1, 2000, that allows Physicians Health Services (PHS) members to receive services from a PHS participating specialist without obtaining a referral from their Primary Care Physician (PCP). Members would still be required to select a PCP for routine care and are encouraged to coordinate care from a specialist through their PCP. While no referral from your PCP is necessary for specialty care, a referral is still required for hospitals and lab work.

Plan year (Continued from page 1)

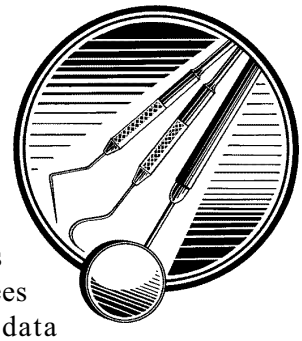
The change to a calendar based plan year will have several benefits for SHBP members.

- The annual periods used for determining **NJ PLUS** and **Traditional Plan** deductibles and coinsurance will match the new plan year, causing less confusion for participants of those plans.
- The new plan year will match the annual plan year used by most SHBP health plans.*
- The Open Enrollment for health, prescription, and dental coverage will coincide with the Open Enrollment period for the State Employee's Tax Savings Program, *Tax$ave*.
- Employees who participate in *Tax$ave,* will be better able to calculate withholding for Unreimbursed Medical Spending Accounts and their estimated tax savings. Any deductibles or other unreimbursed medical expenses from the SHBP benefit year will coincide with the tax year on which *Tax$ave* is based.
- For retired members, the new SHBP plan year matches the Medicare plan year and the annual period for determining Medicare deductibles.

Employees who share their health benefit premiums with the State will not see any increase in premium sharing amounts during the Fall 2000 Open Enrollment. The premiums for all SHBP plans have been set for an 18-month period, from July 1, 2000 through December 31, 2001.

*Most SHBP HMOs use the calendar year for the allocation of certain services such as physical or speech therapy, mental health benefits, and alcohol/drug abuse treatment.

State Employee Group Dental Program changes



The **State Employee Group Dental Program** requires its participating Dental Provider Organizations (DPOs) to credential their dentists and report on all dental services provided to State employees and their families. The data reported by the DPOs allows the State to monitor the quality of dental care provided by the DPOs.

Based on a review of the reported information, several plans have been noted as providing services superior to the high standards required of all participating DPOs. For the first time in many years, three DPOs — **CIGNA, Community Dental Associates,** and **Atlantic Southern** (BeneCare) — will have higher premium levels than the other DPOs. Since State employees pay 50 percent of the dental premium, these plans will cost slightly more than the others. You should remember, however, that the additional cost indicates that these three plans provide you with a superior quality of service.

Statewide DPO, Inc., will no longer be participating in the State Employee Group Dental Program after July 1, 2000. Employees enrolled in this plan must select another dental plan during this Open Enrollment if they wish to retain dental coverage after July 1, 2000.

There have been no other changes to the benefits offered under the State Employee Group Dental Program for the plan year beginning July 1, 2000.

Fact Sheet #37, *State Employee Group Dental Program* provides a comparison of the benefits between the Dental Expense Plan and the DPOs. This fact sheet can be viewed over the Internet at *www.state.nj.us/treasury/pensions/fact37.htm* or obtained by calling the Benefit Information Library (BIL) at (609) 777-1931 and entering selection number 256 when prompted.

Let the Unified Provider Directory help you find a doctor

The State Health Benefits Program's (SHBP) **Unified Provider Directory,** available through the Internet, provides timely and comprehensive information concerning health care providers and facilities who deliver their services through one or more of the SHBP's health care plans.

Updated monthly, the Directory lets you search by name for a provider or hospital or, by entering an address and Zip Code, find the providers and facilities that are most convenient to you and which health plans they accept. The site also includes providers that participate in Horizon's Performance and Cost Effectiveness (P.A.C.E.) network, who offer discounted services to members of the Traditional Plan and NJ PLUS (for out-of-network services). Using a P.A.C.E. provider can reduce your out-of-pocket costs.

Anyone who has access to the Internet, whether at home or in a public library, can view the Unified Provider Directory, health plan descriptions, and other SHBP information by accessing the State Health Benefits Program home page at: *www.state.nj.us/treasury/pensions/shbp.htm*

Open Enrollment

(Continued from page 1)

Along with this issue of the *Health Capsule* you should have received the *State Health Benefits Program Comparison Summary*, which provides an outline of the available plans and compares benefit coverage. Information packets from the different health plans are available from your Human Resources representative or at the health fairs held at various locations during the Open Enrollment. Check with your Human Resources representative to see when a health fair is being held in your area.

Premium sharing changes for the new plan year

New amounts effective July 1, 2000

The new contracts

Unions representing most State employees have settled new contracts that provide for revised premium sharing arrangements with the State. Included in these arrangements are non-aligned employees (those employees whose positions are not eligible for union representation) and employees of the State and State colleges and universities represented by the Communications Workers of America (CWA); the American Federation of State, County, and Municipal Employees (AFSCME) except those at Rutgers and the New Jersey Institute of Technology; the International Federation of Professional and Technical Engineers (IFPTE); the American Federation of Teachers (AFT); and Internal Affairs Investigators under the Fraternal Order of Police (FOP). Also included in the arrangements are all employees of the University of Medicine and Dentistry, employees of the New Jersey Institute of Technology represented by OPIEU Local #32, and all Rutgers employees except those represented by AFSCME.

The contracts are identical with respect to their premium sharing provisions. **There is no premium cost to any employee who enrolls in NJ PLUS.** Employees will pay 5 percent of the premium cost if enrolled in an **HMO** or 25 percent of the premium cost if enrolled in the **Traditional Plan.** These percentages apply regardless of salary level or date of hire. Premium sharing costs for these employees are shown on the Open Enrollment rate chart under the heading New Contract Model.

Premium deductions under the new percentages begin as of pay period 13 (paycheck of June 23, 2000) for State employees paid through Centralized Payroll. Deduction dates for other State employees will vary depending on their employer's payroll schedule.

Employees covered under the new contracts, who accrue 25 years of pension service during the period from July 1, 2000 to June 30, 2003 or who retire with a disability retirement from August 1, 2000 through July 1, 2003 will pay no monthly premium for NJ PLUS or an HMO when they retire. Those who select the Traditional Plan in retirement will pay 25 percent of the premium cost.

Medicare Part B reimbursement remains capped at a maximum of $46.10 for those retirees eligible for this payment.

Employees under the old contracts, who attained 25 years of pension service **on or before June 30, 2000,** remain subject to the contract provisions regarding retired health coverage premium costs that were in effect when they attained 25 years.

Other unions

Employees who are represented by unions which have not settled a new contract with the State will continue to share in the premium cost of the Traditional Plan according to the provisions of their lapsed contracts until a new contract is settled. These groups include (as of press time) the five bargaining units representing judicial employees, the PSA-AAUP at the New Jersey Institute of Technology, the two AFSCME councils at Rutgers University and the AFSCME council at the New Jersey Institute of Technology. Premium sharing costs for these employees are shown on the Open Enrollment rate chart under the heading Old Contract Model.

Several unions have either no current contract or contracts that do not require premium sharing. These include the State Police Troopers/Sergeants/Lieutenants, the four PBA bargaining units representing State employees, and the two bargaining units at the New Jersey Institute of Technology representing law enforcement employees.

Premium sharing rate charts

Rate charts for Open Enrollment 2000 have been distributed to State employees and show the premium sharing amounts under both the New Contract Model and, when it applies, the Old Contract Model. The charts include the cost of all medical plans and coverage levels. The rates are effective as of July 1, 2000.

If you are unsure of your contract affiliation or have other questions about premium sharing, contact your union representative or Human Resources representative.

Premium sharing and the Premium Option Plan

Premium sharing may not cost you as much as you may think. If you premium share **and** participate in the State's **Premium Option Plan** (POP) your premium sharing amounts are paid from your pre-tax income. This reduces your taxable income and results in a savings of federal income tax, along with Medicare and Social Security taxes, that helps to offset the cost of the shared premiums and puts that income back into you pocket (see chart at right).

The best part about the POP is that you are probably already saving on your taxes without knowing it. Enrollment in the POP is *automatic* each October, as part of the State's annual *Tax$ave* Open Enrollment, and becomes effective the following January (unless you decline enrollment by completing a POP Declination form). For more information about the Premium Option Plan and other *Tax$ave* programs that can save you money, see your Human Resources representative or visit the Division of Pensions and Benefits' *Tax$ave* Internet page at: *www.state.nj.us/treasury/pensions/fact44.htm*

Comparison of tax savings available with the Premium Option Plan

Individual participating in POP

Net Biweekly Salary*	$1,500.00
Less Dental Premium**	$22.52
Less 25% of Traditional Plan**	$84.45
Taxable Salary	$1,393.03
Less Estimated Taxes:	
Federal (15%)	$208.96
FICA	$106.57
Salary after Taxes	$1,077.50
Spendable Income **with** POP	$1,077.50

Individual NOT participating in POP

Net Biweekly Salary*	$1,500.00
Taxable Salary	$1,500.00
Less Estimated Taxes:	
Federal (15%)	$225.00
FICA	$114.75
Salary after Taxes	$1,160.25
Less Dental Premium**	$22.52
Less 25% of Traditional Plan **	$84.45
Spendable Income **without** POP	$1,053.28

Spendable Income **with** POP	$1,077.50
Spendable Income **without** POP	$1,053.28
Additional Spendable Biweekly Income with POP	**$ 24.22**
Annual Savings *with* POP* **	**$ 629.72**

* Salary after state income tax and pension (414h) deduction.
* * Family coverage, Dental Expense Plan and Traditional Plan Premium Sharing – biweekly rates as of July 2000.
* * * Savings assuming a federal tax rate of 15%. At the 28% tax bracket, the annual savings would be higher.

Important notice on women's health

The **Women's Health and Cancer Rights Act,** signed into law by Governor Whitman in 1998, requires group health plans that cover mastectomies to also cover reconstructive surgery or other related services following a mastectomy. The services to be included are reconstruction of the breast on which surgery was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and the provision of prostheses and services in connection with other complications resulting from the mastectomy. These services are available under all plans in the SHBP.

IF YOU HAVE LOST THE ID CARD FOR YOUR STATE HEALTH BENEFITS PROGRAM (SHBP) HEALTH OR PRESCRIPTION DRUG PLAN, a replacement ID card can be obtained by calling the plan. All cards are produced and mailed to SHBP plan members by the individual health plans. Prescription drug cards are produced by Horizon Blue Cross Blue Shield of New Jersey. Telephone numbers for SHBP participating health plans are available on the *State Health Benefits Program Comparison Summary* distributed as part of this year's Open Enrollment information. Or visit the SHBP over the Internet to view a listing of plan names and telephone numbers at: *www.state.nj.us/treasury/pensions/comprsn.htm*

Health plan choices: How should you choose your health plan?

Choosing the right health plan is important. It can also be difficult. To choose the best health plan you should consider the following questions:

1. Is your doctor or health care provider available in the health plan?

If you have a doctor or other type of provider you want to see, find out if he or she participates in the health plan. To get this information, review the health plan's provider directory, the SHBP's **Unified Provider Directory** (see page 3), or call the provider's office or the health plan to confirm this information.

If you are looking for a new doctor, review the list of doctors in the health plan's provider directory for someone that appeals to you. Next, check with that doctor to confirm that they are accepting new patients.

Are there other providers, specialists, or facilities you think you may need? Don't forget to check those out too. The SHBP's Unified Provider Directory lets you search by Zip Code for a convenient doctor or hospital.

2. Does the health plan offer the benefits you want?

Based on what you know about your family's health, does the plan cover health services you and your family will need? For a comparison of the benefits offered by each SHBP health plan, see the *State Health Benefits Program Comparison Summary* (included with your Open Enrollment materials).

3. How much will it cost?

To compare copayment, coinsurance, and annual deductible amounts for various plans, see the *State Health Benefits Program Comparison Summary.* If you are subject to premium sharing, check the rate charts included with your Open Enrollment materials for your biweekly or monthly cost (see page 4 for additional information about premium sharing).

Remember: While it's tempting to choose the health plan that costs less, it's important to look at quality first.

*(Continued on page 7, see **Choices.**)*

SHBP COMPARISON OF HEALTH MAINTENANCE ORGANIZATIONS BASED ON DEPARTMENT OF HEALTH AND SENIOR SERVICES — 1999 NJ HMO PERFORMANCE REPORT

PLAN NAME	CATEGORIES					
	QUALITY AND EASE OF ACCESS TO SERVICES	SATISFACTION WITH DOCTORS & MEDICAL CARE	QUALITY OF PREVENTIVE CARE	QUALITY OF CARE FOR KIDS	QUALITY OF TREATMENT FOR CHRONIC ILLNESS	QUALITY OF SERVICES FOR FREQUENT USERS OF THE PLAN
Aetna US Healthcare	11	8	9	9	11	10
AmeriHealth	12	11	6	12	10	12
CIGNA Health Care	8	8	4	8	6	8
Horizon HMO[1]	10	8	7	8	11	8
Oxford Health Plan	8	8	10	10	8	8
Physicians Health Services	8	8	8	7	4	8

Each category is based on four measures. The score summarizes how well a plan performed on the four measures in each category. The higher the score, the better the rating. In each measure 3 points were given for an above average rating, 2 points for an average rating, and 1 point for a below average rating. The highest score for each category is 12, the lowest score is 4.

[1]The **NJ PLUS in-network plan** (in New Jersey) shares the same panels of providers as Horizon HMO.

University Health Plans was not required to report and is not shown.

For rating details see the *1999 New Jersey HMO Performance Report: Compare Your Choices.*

Choices (Continued from page 6)

4. Which health plans perform the best?

You can compare quality ratings of various HMO's with the New Jersey Department of Health and Senior Services' *1999 New Jersey HMO Performance Report: Compare Your Choices.* A summary of selected report data, as it relates to HMOs in the SHBP, is provided in the chart on page 6.

From the health plans that seem to best fit your needs, check the issues that are most important to you and your family. For example, if you have a young child, you might be most interested in the performance measures in the Care for Kids section of the report. Be careful, however, not to make decisions based on small differences that are not meaningful. Look at all factors that contribute to a health plan's performance, not just results for a single measure.

To obtain a copy of the *1999 New Jersey HMO Performance Report: Compare Your Choices*, contact the New Jersey Department of Health and Senior Services, Office of Managed-Care, PO Box 360, Trenton, NJ 08625-0360, or call 1-888-393-1062. The report is also available over the Internet at: *www.state.nj.us/health*

To get additional information from the health plans you are most interested in joining, see the telephone numbers for SHBP health plans listed in the *State Health Benefits Program Comparison Summary.*

(The questions and answers in this article were adapted from the *1999 New Jersey HMO Performance Report: Compare Your Choices.*)

HIPAA requirements for 2000

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. As self-insured non-federal government plans, the Traditional Plan and NJ PLUS may elect exemption from compliance with any HIPAA provisions on a year-to-year basis.

For the plan year that began January 1, 2000, all SHBP health plans will meet or exceed the federal requirements with the exception of mental health parity for the Traditional Plan and NJ PLUS. Parity requires that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

The State Health Benefits Commission has filed an exemption from the mental health parity requirement with the federal Health Care Financing Administration for calendar year 2000. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS will not change, with the exception for *biologically-based* mental illness as covered under Chapter 441, Public Law of 1999 (see *Mental health parity,* on page 8). Maximum annual and lifetime dollar limits for mental health benefits are outlined in the *State Health Benefits Program Comparison Summary.*

COBRA law changes

Effective January 1, 2000, new federal regulations have resulted in two changes to the State Health Benefits Program's (SHBP) administration of coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. COBRA requires that your employer must offer you the opportunity to temporarily extend your group health insurance coverage, at your expense, in certain instances where coverage under the plan would otherwise end.

The new rules changed the relationship between COBRA and the federal and State Family Leave Acts. Previously, leave taken under the federal and/or State Family Leave Act was subtracted from a member's COBRA eligibility period. Under the new rules, the time a member spends on federal or State family leave will not count as part of the COBRA eligibility period.

Further changes broaden COBRA rules regarding open enrollment. A former employee, or dependent, who elected to enroll under COBRA has the same opportunity to enroll in any other SHBP coverage offered by the former employer during the SHBP Open Enrollment period (as long as the employee or dependent was eligible for that coverage when first enrolling in COBRA). For State employees, eligible coverage would include an SHBP medical plan, dental plan, and the State Prescription Drug Program. However, all COBRA benefits will end no later than the original COBRA termination date. The addition of a benefit during the Open Enrollment does not extend the maximum COBRA coverage period.

All COBRA enrollees receive Open Enrollment information, mailed directly to the address on file with the SHBP, prior to the start of the Open Enrollment period in April 2000.

New health care legislation

Governor Christine Todd Whitman recently signed into law the following legislation which affects your SHBP coverage.

Mental health parity

Effective for SHBP health plans on July 1, 2000, Chapter 441, Public Law of 1999 requires that coverage for *biologically-based* mental illness be provided under the same terms and conditions as provided for any other illness under the medical plan.

"Biologically-based mental illness" includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Annual and lifetime caps on eligible expenses for treatment of other types of mental illness or functional nervous disorders (a broader category than biologically-based mental illness) will remain for all plans.

New mammogram law

Effective January 10, 2000, Chapter 341, Public Law of 1999 requires health insurers, including HMOs, to provide coverage of annual mammograms for women age 40 and over. All SHBP health plans meet or exceed these requirements.

Continuing treatment with a physician who leaves a managed-care plan

Chapter 390, Public Law of 1999 requires managed-care plans to provide for the continuation of treatment by a physician, **in the event that the physician is no longer employed by or under contract with the plan.** Specifically, continuation of treatment is allowed for the following conditions.

- For a period not to exceed six months in the case of post-operative follow-up care.
- For a period not to exceed one year in the case of oncological treatment and psychiatric treatment.
- Through the duration of a pregnancy and up to six weeks after delivery in the case of obstetrical care.

The continuation of treatment by a particular physician is at the option of the covered member.

The law also requires managed-care plans to provide continued coverage of other health care services, by a physician who is no longer employed by or under contract with the plan, for up to 120 calendar days **in cases where it is medically necessary** to continue treatment with that physician.

The SHBP HMOs which are affected by this law are the Oxford Health Plan, AmeriHealth HMO, Physicians Health Services, and University Health Plans, Inc. This law does not pertain to the SHBP's self-insured plans which are the Traditional Plan, NJ PLUS, Aetna US Healthcare, CIGNA Health Care, and Horizon HMO.

New Jersey SHBP

Health Capsule

Internet Edition

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Health Capsule is published periodically for state employees and is designed to keep employees informed about developments in their health benefits program. The newsletter will address issues affecting your health, prescription, and dental benefits and will include articles on new or proposed legislation, NJ Administrative Code changes, decisions of the Health Benefits Commission, and national issues affecting our programs.

The selections in this publication are for information purposes only and, while every attempt at accuracy is made, it cannot be guaranteed.

If you would like to see any particular health benefits issue addressed, please forward your ideas to Health Capsule, Division of Pensions and Benefits, Office of Client Services, P.O. Box 295, Trenton, NJ 08625-0295.

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